An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2019-0437
Sector:	Insurance
Product / Service:	Payment Protection
Conduct(s) complained of:	Rejection of claim - fit to return to work
Outcome:	Rejected

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The Complainant is a member of a group income protection scheme which is underwritten by the Provider. This complaint relates to an income protection claim submitted by the Complainant in March 2017, on the grounds of disablement. Following assessment, the Provider declined the Complainant's claim on the grounds that she did not meet the definition of disablement contained in the policy conditions.

The Complainant disputes the Provider's assessment of her claim.

The Complainant's Case

The Complainant submitted an income protection claim to the Provider in **March 2017**, as she was unfit to return to work due to *"depression, anxiety, work related stress, bullied at work."* The Provider denied her income protection claim as it concluded from the medical evidence obtained that the Complainant did not meet the policy definition of disablement.

In her correspondence to this Office dated **1 December 2017**, the Complainant submits as follows:

> *"Currently off work sick. Since Jan 2017. Received one payment from [Provider] payment in July 2017. [Provider] state they will no longer pay, they have ceased payments. My GP and Occupational Health doctor state I am unfit for any work/duties at this time.*

…

I would like [Provider] to continue paying my payment protection, I am currently in financial stress which is impacting on my mental health further."

The Complainant's complaint is that the Provider wrongly or unfairly declined her income protection claim.

The Provider admitted the Complainants claim in so far as it agreed to make payments up to **1 July 2018** to allow the Complainant time to make arrangements to return to work. The Provider wrote to the Complainant by letter dated **25 May 2017** to explain this, and also outlined its appeal process.

The Complainant appealed the Provider's decision and she furnished the Provider with a report from her GP in support of this appeal indicating that she was unfit to return to work. She further furnished the Provider with two reports from her employer's occupational health department which also indicated that she was unfit for work. However, the Provider's position is that it found that these reports did not contain any evidence to alter its opinion on the Complainant's ability to return to work and refused her appeal.

The Provider's Case

The Provider states that under the terms of the Complainant's income protection scheme, an income protection claim is payable when the claimant meets the definition of disablement, as follows:

"total disablement shall be deemed to exist where (a) the Insured Person is unable to carry out the duties pertaining to her normal occupation by reason of disablement arising from bodily injury sustained or sickness or illness contracted and (b) the Insured Person is not engaging in any other occupation (whether or not for profit or reward or remuneration including benefit in kind)."

The Provider states that the Complainant completed an Income Protection Claim Notification Form in **March 2017**, advising that she was complaining of *"depressions, anxiety, work related stress, bullied at work."*

The Provider maintains that as part of the initial assessment of her claim, it arranged for the Complainant to undertake a telephone interview on **3 April 2017** with a nurse and on this call the Complainant provided more details of her medical conditions and work circumstances.

After that interview, the Provider requested a report from the Complainant's General Practitioner and arranged for her to attend a Medical Examination with a Consultant Psychiatrist on **11 May 2017**.

/Cont'd…

The Provider received the report of the Consultant Psychiatrist on **17 May 2017** wherein it was noted that the Complainant *"would love to be back at work tomorrow but the bullying issue has to be sorted out first."* Regarding the Complainant's fitness for work, it was advised *"it is my opinion that [the Complainant] is fit to carry out her normal occupation. The main issue is a dispute at work, a grievance procedure which has not been dealt with. She has been out of work for 5 months and there has been no mediation."*

The Provider then, in acknowledgement of the Complainant's recent medical history and the fact that she had received in-patient treatment in the recent past, states that it decided to admit the claim and make payments up to **1 July 2017** to allow the Complainant time to make arrangements to return to work.

The Provider wrote to the Complainant by letter dated **25 May 2017** to explain this, and also outlined its appeal process.

On **12 June 2017**, the Provider received a report from the Complainant's General Practitioner in support of her appeal. The Provider therefore arranged for the Complainant to attend a further Medical Examination with a Consultant Psychiatrist on **21 July 2017**. In that report, regarding the Complainant's fitness for work, it was advised that:

> *"In my opinion [the Complainant] is currently fit to carry out her normal occupation. There is no objective evidence of disabling psychiatric illness that is preventing her from performing the material and substantial duties of her normal occupation. Any residual symptoms are not disabling in nature… There are significant industrial relations issues in this case and these need to be addressed in order that [the Complainant] can return to work. Regretfully, I am unable to conclude that it is a psychiatric illness that is preventing her from working, since it is these industrial relations issues which are the main factor."*

The Provider maintains that, at that point, the Complainant did not meet the definition of disablement as required by the policy, and that she was fit to return to her normal occupation.

The Provider then wrote to the Complainant on **19 September 2017** confirming that it would not be making any more payments under the policy.

In **October 2017**, the Complainant wrote to the Provider to state that she disagreed with its decision. She also provided two reports from her employer's Occupational Health Department, dated **24 May 2017** and **7 September 2017**, stating that she was unfit for work.

The Provider maintains that there were no additional details provided and no objective evidence in these reports to support that view and, having reviewed them, replied to the Complainant on **19 October 2017** confirming its refusal of her appeal.

/Cont'd…

The Provider maintains that the objective medical evidence obtained regarding the Complainant, namely two separate medical examinations, confirms that the Complainant is fit to return to carry out her normal occupation, and, therefore, she does not meet the definition of disablement as per the policy.

The Provider is of the view that industrial relations issues are preventing the Complainant from returning to her normal occupation and that these cannot be a factor to be taken into account by the Provider when deciding on a person's medical fitness for work. The Provider states that it is satisfied from the medical evidence obtained that the Complainant does not meet the policy definition of disablement and that it has declined her income protection claim in accordance with the policy terms and conditions.

The Complaint for Adjudication

The Complainant's complaint is that the Provider wrongly or unfairly declined her income protection claim.

Decision

During the investigation of this complaint by this Office, the Provider was requested to supply its written response to the complaint and to supply all relevant documents and information. The Provider responded in writing to the complaint and supplied a number of items in evidence. The Complainant was given the opportunity to see the Provider's response and the evidence supplied by the Provider. A full exchange of documentation and evidence took place between the parties.

In arriving at my Legally Binding Decision I have carefully considered the evidence and submissions put forward by the parties to the complaint.

Having reviewed and considered the submissions made by the parties to this complaint, I am satisfied that the submissions and evidence furnished did not disclose a conflict of fact such as would require the holding of an Oral Hearing to resolve any such conflict. I am also satisfied that the submissions and evidence furnished were sufficient to enable a Legally Binding Decision to be made in this complaint without the necessity for holding an Oral Hearing.

A Preliminary Decision was issued to the parties 24 May 2019, outlining the preliminary determination of this office in relation to the complaint. The parties were advised on that date, that certain limited submissions could then be made within a period of 15 working days, and in the absence of such submissions from either or both of the parties, within that period, a Legally Binding Decision would be issued to the parties, on the same terms as the Preliminary Decision, in order to conclude the matter.

/Cont'd…

In the absence of additional submissions from the parties, the final determination of this office is set out below.

The principal issue in dispute is whether or not the Complainant's income protection claim satisfies the policy criteria for payment of disablement benefit and whether, in this instance, on the basis of an objective assessment of the medical evidence submitted, the Provider has adequately assessed the claim and was reasonably entitled to arrive at the decision it did upon assessment of the medical evidence received. Both parties to the complaint have submitted medical evidence in this regard. To benefit under the policy, the Complainant must show that she is *"unable to carry out the duties pertaining to her normal occupation by reason of disablement arising from bodily injury sustained or sickness or illness contracted"*

Timeline of Medical Evidence

The Complainant submitted a Claim Notification Form to the Provider in **March 2017**, advising that she was complaining of *"depressions, anxiety, work related stress, bullied at work."*

As part of the initial assessment of her claim, the Provider arranged for the Complainant to undertake a telephone interview on **3 April 2017** with a Nurse where the Complainant provided more details of her medical conditions and work circumstances.

After that interview, the Provider requested a report from the Complainant's General Practitioner and arranged for her to attend a Medical Examination with a Consultant Psychiatrist on **11 May 2017**.

The Provider received the report of the Consultant Psychiatrist (Dr M.) on **17 May 2017** wherein it was noted that the Complainant *"would love to be back at work tomorrow but the bullying issue has to be sorted out first."* Regarding the Complainant's fitness for work, it was advised *"it is my opinion that [the Complainant] is fit to carry out her normal occupation. The main issue is a dispute at work, a grievance procedure which has not been dealt with. She has been out of work for 5 months and there has been no mediation."* Regarding the future prognosis of the Complainant's condition, Dr M. replied *"The prognosis is that of her dispute with her employers rather than that of a psychiatric disorder."*

The Provider then decided to admit the claim and make payments up to **1 July 2018** to allow the Complainant time to make arrangements to return to work. The Provider wrote to the Complainant by letter dated **25 May 2017** to explain this, and also outlined its appeal process.

On **12 June 2017**, the Provider received two letters from the Complainant's General Practitioner in support of her appeal, dated **18 May 2017 and 8 June 2017**. The letter dated **18 May 2017** notes the Complainant presented to the surgery stating that she had been the victim of work related bullying which had been an ongoing issue for two years and had not resolved. She was noted to have symptoms including low mood and difficulty getting to

/Cont'd…

sleep. It was also outlined that the Complainant *"is unable to carry out any of the duties of* letter dated 8 June 2017 notes that there has been no resolution of the Complainant's work related stress and she continues to have symptoms of disturbed sleep, worrying about work and low mood. The opinion was that *"she is clinically depressed and anxious and is unfit for any type of work and will be unfit for any work as long as she is symptomatic."*

The Provider therefore arranged for the Complainant to attend a further Medical Examination with a Consultant Psychiatrist on **21 July 2017**, Dr K. who advised that:

> *"In my opinion [the Complainant] is currently fit to carry out her normal occupation. There is no objective evidence of disabling psychiatric illness that is preventing her from performing the material and substantial duties of her normal occupation. Any residual symptoms are not disabling in nature… There are significant industrial relations issues in this case and these need to be addressed in order that [the Complainant] can return to work. Regretfully, I am unable to conclude that it is a psychiatric illness that is preventing her from working, since it is these industrial relations issues which are the main factor."*

It was also noted that when asked what needs to change in order for her to return to work she replied *"the work environment."*

The Provider was of the opinion at that point that the Complainant did not meet the definition of disablement as required by the policy, and that she was fit to return to her normal occupation. The Provider wrote to the Complainant on **19 September 2017** confirming that it would not be making any more payments.

In **October 2017**, the Complainant wrote to the Provider to state that she disagreed with its decision. She also provided two reports from her employer's Occupational Health Department, dated **24 May 2017** and **7 September 2017**, stating that she was unfit for work.

The Provider maintained that there were no additional details provided and no objective evidence in these reports to support that view and, having reviewed these, replied to the Complainant on **19 October 2017** confirming its refusal.

The Complainant then provided another report from her employer's Occupational Health Department dated **27 November 2017** which stated that she was unfit for work. The Provider was of the view at that point that there were no additional details provided therein and no objective evidence offered to support the view.

On **26 September 2018**, by email to this Office, the Complainant furnished a further letter from her employer's Occupational Health Department. This report provided that the Complainant should be excused from working with the individual she had previously filed a grievance against. It outlined *"In my medical opinion she is fit for a phased return to work and should be assigned to a different location under different management."* She also states *"We do not believe that Occupational Health can provide any further assistance with regards to medical evidence on [the Complainant]'s return to work… This is an industrial relations matter and needs to be dealt with urgently."*

/Cont'd…

The Provider maintained, in a response dated **4 October 2018**, that there are no medical reasons currently preventing the Complainant's return to work and that non-medical factors are the reason for her ongoing absence from work.

Analysis

The Policy is designed to operate in tandem with the employer's sick pay arrangements, so that the insured person receives a total income of 75% salary from all sources when a claim is payable. According to the information received from the Complainant's employers, full salary continued to be paid by them up to **February 2017**, so the Provider's liability commenced after that date. The Complainant went off pay completely on **16 May 2017** and the Provider's liability increased from that date. However, the Complainant's employers confirmed that she was placed back on full pay for the period **17 March 2017 to 2 May 2017**, so the Provider had no liability for that period of time.

The total benefit paid to the Complainant under her claim from **18 February 2017 to 1 July 2017,** excluding the period that the Complainant received full salary was €7,376.15 gross, subject to PAYE and USC. The net amount paid was €4,537.00.

I note that the potential benefit payable that would be under the claim at present, assuming the Complainant has no entitlement to Temporary Rehabilitation Remuneration from her employer, is €42,172 per annum.

Under the terms of the Income Protection Scheme, an income protection claim is payable when the claimant meets the definition of disablement, as follows:

> *"…total disablement shall be deemed to exist where (a) the Insured Person is unable to carry out the duties pertaining to her normal occupation by reason of disablement arising from bodily injury sustained or sickness or illness contracted and (b) the Insured Person is not engaging in any other occupation for profit or reward or remuneration".*

The claim may be turned down, or stopped, by the Provider where, on the basis of the medical evidence, the level of disablement is not such that it prevents the insured person from pursuing their normal occupation. If there is no objective medical reason why a claimant is prevented from carrying out the normal duties of their occupation, there is no ground for a payment of disablement benefit by the Provider.

It is important to stress that, from the point of view of assessing this complaint, it is not the role of this Office to comment on, or form an opinion as to the nature or severity of the Complainant's condition, but rather to establish whether, on the basis of an objective assessment of the medical evidence submitted, the Provider has adequately assessed the claim and was reasonably entitled to arrive at the decision it did upon assessment of the medical evidence received.

/Cont'd…

I have given careful consideration to the submissions made in this complaint. I have reviewed the medical evidence submitted by both parties to the complaint. The Provider has submitted the reports of two medical examinations carried out by two Consultant Psychiatrists. The first psychiatric assessment took place on **11 April 2017** (Dr M) and included a Structured Inventory of Malingered Symptomatology (SIMS).

The second psychiatric assessment took place on **21 July 2017** (Dr K.), and included a Montgomery-Asberg Depression Rating Scale (MADRS), a Hamilton Anxiety Rating Scal (HAM-A), and a psychiatric interview with the Complainant.

The Provider has also submitted a copy of the medical evidence it received from the Complainant's employers as part of the assessment of her claim, as I have noted above. The Complainant provided reports from her employer's Occupational Health Department, dated **24 May 2017, 7 September 2017** and **27 November 2017**, ticking a box which states she was unfit for work. There are no additional details provided and no objective evidence is included in these reports, except for the words *"[The Complainant] remains very unwell."*

I have also received a copy of the two letters from her General Practitioner, to which I have referred above, dated **18 May 2017 and 8 June 2017** respectively.

From a consideration of the medical reports submitted I accept that it is acknowledged in these reports that the Complainant suffers depressive and anxiety symptoms, and that she receives counselling therapy and, for a short while, received treatment in the form of antidepressant medication. However, the medical opinion differs on the question of whether these amount to a disablement within the terms of the policy and, if so, whether by reason of these the Complainant is unable to carry out the normal duties of her occupation.

The Complainant's claim that she is unable to carry out the duties of her normal occupation is supported by her General Practitioner's letters. The letter dated **18 May 2017** notes the Complainant presented to the surgery stating that she had been the victim of work related bullying which had been an ongoing issue for two years and had not resolved. She was noted to have symptoms including low mood and difficulty getting to sleep. It was also outlined that the Complainant *"is unable to carry out any of the duties of her normal occupation because she is still depressed and anxious and another contributing factor is the fact that she herself is a psychiatric nurse working in the psychiatric services. She is not able to cope at the moment with her own difficulties never mind deal with other patients difficulties or interact with colleagues."* The letter dated **8 June 2017** notes that there has been no resolution of the Complainant's work related stress and she continues to have symptoms of disturbed sleep, worrying about work and low mood. The opinion was that *"she is clinically depressed and anxious and is unfit for any type of work and will be unfit for any work as long as she is symptomatic."*

Her claim is also supported by two reports from her employer's Occupational Health Department, dated **24 May 2017 and 7 September 2017**, ticking a box which states she was unfit for work. There are no additional details provided and no objective evidence in these reports, except for the words *"[The Complainant] remains very unwell"* to support that view.

/Cont'd…

The Provider's view is supported by the report of the Consultant Psychiatrist (Dr M.) on **17 May 2017** wherein it was noted that the Complainant *"would love to be back at work tomorrow but the bullying issue has to be sorted out first."*

Regarding the Complainant's fitness for work, it was advised *"it is my opinion that [the Complainant] is fit to carry out her normal occupation. The main issue is a dispute at work, a grievance procedure which has not been dealt with. She has been out of work for 5 months and there has been no mediation."* Regarding the future prognosis of the Complainant's condition, Dr M. replied *"The prognosis is that of her dispute with her employers rather than that of a psychiatric disorder."*

The Provider's view is also supported by the report of a Consultant Psychiatrist on **21 July 2017**, Dr K. In that report, regarding the Complainant's fitness for work, it was advised that:

> *"In my opinion [the Complainant] is currently fit to carry out her normal occupation. There is no objective evidence of disabling psychiatric illness that is preventing her from performing the material and substantial duties of her normal occupation. Any residual symptoms are not disabling in nature… There are significant industrial relations issues in this case and these need to be addressed in order that [the Complainant] can return to work. Regretfully, I am unable to conclude that it is a psychiatric illness that is preventing her from working, since it is these industrial relations issues which are the main factors."*

It was also noted that when asked what needs to change in order for her to return to work she replied *"the work environment."*

It is evident that work-related issues have been a recurring aspect of the Complainant's claim for disablement since the outset, both in her own account of the circumstances of her claim, and in the reports of the medical examiners who have assessed her. These issues are detailed in the medical reports of the independent examiners, as an aspect of the circumstances surrounding the Complainant's claim and her potential return to the workplace. The medical evidence submitted, both by the Complainant and by the Provider, links problems in the workplace with the Complainant's anxiety and depressive symptoms. The presence of non-medical factors such as difficulties in the workplace cannot, be a material consideration when assessing a person's fitness for work under the terms of the policy. The wording of the policy refers to disablement *"arising from bodily injury sustained or sickness or illness contracted".* Difficulties in the workplace arising from an industrial relations/grievance issue, notwithstanding their serious impact, cannot reasonably be considered to be a bodily injury or a sickness or an illness contracted.

In order for the Complainant to benefit from the policy, the Complainant must fall within the definition of disablement under the policy. In assessing whether the Complainant fell within this definition, the Provider was entitled to be guided by the objective medical evidence obtained during the course of the claim, whilst also having regard to information provided by the Complainant, including any medical evidence. I find that it was not unreasonable, having regard to all the evidence available to it, for the Provider to determine

/Cont'd…

that the Complainant did not fall within the policy definition of disablement, that she was capable of carrying out the duties of her normal occupation on a full time basis and that her absence was due to work place issues rather than medical issues.

For the reasons set out above, this complaint is not upheld.

Conclusion

My Decision pursuant to ***Section 60(1)*** of the ***Financial Services and Pensions Ombudsman Act 2017***, is that this complaint is rejected.

The above Decision is legally binding on the parties, subject only to an appeal to the High Court not later than 35 days after the date of notification of this Decision.

GER DEERING
FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

17 June 2019

Pursuant to *Section 62* of the *Financial Services and Pensions Ombudsman Act 2017*, the Financial Services and Pensions Ombudsman will publish legally binding decisions in relation to complaints concerning financial service providers in such a manner that—

(a) ensures that—
(i) a complainant shall not be identified by name, address or otherwise,
(ii) a provider shall not be identified by name or address,
and
(b) ensures compliance with the Data Protection Regulation and the Data Protection Act 2018.